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Role and Responsibility of Local Government & Business Leaders in Pre-Event Planning & Post-Event Recovery

Introduction

I was asked today to speak to you about the Texas experience during Katrina and Rita and how it underscored the importance of effective COOP planning, mitigation and recovery. Fundamentally, in order to accomplish these individual goals effectively, the emphasis must be on planning as a whole. I want to talk to you about these issues in reverse.

Hurricanes Katrina and Rita have left an indelible mark on the City of Houston. Unprecedented, these mammoth evacuations and the unique social circumstances subsequently created allowed us to test plans in a manner never before envisioned and expose deficiencies. But more importantly, these events allowed us to turn planning and response on its ear and think outside the box.

Rather than focus on the specific thing we accomplished, I am taking the Stephen Covey approach. There were many lessons learned during these events, they can all be summarized by six principles: 1) Learn to Say No 2) Create a Book of Lists 3) Leverage the Private Sector 4) Emphasize the Human Services in Health and Humans Services 5) Integrate Emergency Response Into the Day-to-Day and 6) Prioritize the Workforce. Let this principles percolate and apply them to your individual organizations and circumstances.

It is only through the implementation of these six principles will we be able to adequately plan,

efficiently respond and quickly provide a sense of normalcy in a public health emergency.

Learn to Say No

This phrase seems to be a contradiction to our mission, but it is not. We must acknowledge that we simply do not have the infrastructure to provide all the support for a response. No where is this more true than in public health. By this, I do not mean to imply that we must suppress our "Can Do" attitude or quiet our desire to help. We must instead, define clearly our limitations. Trying to accomplish goals despite our limitations only worsens the situation. It creates inefficiency, fatigues the response and delays resources. Empirically, it defeats the entire premise of the system devised by the federal government that we have been told to rely on–NIMS and the NRP and erodes the balance that it strives to create–the delicate balance between needs and allocation of resources. Furthermore, in light of the Katrina response, the more dependence we create, the more accountability is demanded. This is the only way to ensure fidelity in the system.

Addressing our strength and weaknesses afore hand forces one to be introspective and address his capabilities objectively and honestly. The benchmark is now shifted, it is not this implicit, "How to we accomplish all of this?" but rather, "What can we accomplish effectively?" Simply stated we need only answer what we can do. Once this has been done, assets and resources can be accurately determined and thus capabilities quantified. Additionally, needs are now known in advance of an emergency, not during the emergency. Thus, the focus can be efficient planning and addressing the emergency rather than searching for services in the midst of chaos. To not do this compounds inefficiency and in our business that equates to lives lost.

We encountered this issue in the evacuations of special needs. Initially, the identification, quantification, evacuation and all the related issues were placed on the back of public health. Admittedly there were indeed medical issues, but not exclusively. However, because they did not fall into any other discrete area they were our responsibility to bear. But, through the Office of Emergency Management we were able to clearly convey our position that we were unable to provide for the transportation. Instead we were able to get private transportation entities to come to the table and accept the responsibility for these components. As for the assessment and provision of specific services, we were successful in delegating these to nursing schools, medical schools and private agencies. All of us working together.

This is the underlying philosophy of the NRP. Ultimate control is retained by the local jurisdiction; however, the responsibility for resources is allocated up the chain. We were leading by example.

In order to say no, though you have to know *who* can say yes.

Create a Book of Lists

When I first became an emergency response planner, I was very dogmatic and structured like most others. I shared the frustrations that all too often plans were really "concepts of operations" and left the rest up to the imagination. I now recognize that is a very savvy approach to planning with one caveat: just as we are taught to resource type, we must inventory the response. This provides the framework for the "imagination" in the response.

We had never planned for an emergency of this magnitude. Where is "2.5 million people evacuate

while 200,000 migrate to your city" on the 15 National Planning Scenarios. This was one of the largest evacuations in U.S. history. But, there was no damage/or devastation to us. Instead, the "damage" was the massive influx of people into the city and the demand placed on services already stretched thin. Our plans did not apply.

Using our experience in the shelters during Katrina and Rita as a template, the model we employed for the overall response was that of a social worker. Just as a social worker is knowledgeable of all the various resources available and assesses a client for interface with those services so should our response. We should characterize the services offered and codify them. Then like a cafeteria plan, we can seek out those who provide the services needed. This is a practice utilized almost daily. How many of you have an HMO or PPO. You may know this concept better as a provider handbook.

Equally important, this then identifies for us the groups, agencies, etc. that we need to bring to the table and plan with. Not just have a series of MOU's that lack the underlying relationship. But rather develop a long-term relationship. These groups in turn can leverage their expertise in the service area they represent to bring more parties to the table. This is, once again, what an integrated response is about—bringing various groups to the table who then provide a seamless response.

And ultimately, that seamless response requires private sector.

Leverage the Private Sector

I define the private sector broadly. It includes any group that's not the public sector. The private sector is more than just groups that provide services or resources and who happen to be obligated

through an MOU. It is about understanding their processes and scales of efficiencies and striving for the same. Knowing that we do not have all the resources to adequately respond, we must embrace the private sector and its methods. They have developed processes and procedures to efficiently provide services whether it is human capital or capital assets. By utilizing these models, we enhance our abilities as well.

Additionally, the more we try to adapt and make ourselves more compatible, the more successful we will be from an integrative standpoint. This is not to say that flexibility isn't a two-way street. It is as much about learning their processes as it is understanding ours. And quite frankly, ours are usually quite limiting. This is a fundamental of interoperability and workforce management. Just because our mandates are different doesn't mean our models must be. In fact, using the private sector as a model will help us to continue to exist with our narrow margins and ever decreasing funding.

To some degree, the private sector has revolutionized hierarchies with its business organizations and management structures while the public sector has developed NIMS as a means to navigate its own bureaucracy.

During Katrina and Rita there were two good examples of leveraging the private sector. The first occurred in the Clinic operations in the shelters and the second was the development of healthcare systems in the community.

In the shelters, Hermann Memorial Health Care System and HCA provided logistic support to the

clinic operations. Quest provided lab services rather than tiring up our laboratory services. Quite frankly they were able to turn around results on the same schedule as private offices something that we cannot do.

With nearly 200,000 additional uninsured—most chronically ill—added to our existing 500,000 uninsured population, our public health systems were in crisis. However, the private healthcare providers and public systems met to develop a third system, one that drew from the strengths of the private sector (services and resources) and the infrastructure of the public sector (city/county clinics, FQHCs, and faith-based clinics) and more importantly, their ties to the communities.

Each side played off the strengths of the other striving to pattern the collective body after a private-sector model. In the end thought, while successful, this "novel" healthcare system still could not keep up with the human services needs.

Emphasize the Human Services in Health & Human Services

Health and Human Services in not about human services. I don't mean that as a negative statement, just a reality we must address. The focus of health departments since the beginning has been on communicable diseases. The addition of human services has been a relatively recent addition. However, the funding has not followed. This must change. This narrow view of the mission of a health department must yield to this holistic approach to public health: disease prevention of the body and the soul.

The deluge of people into Houston due to Katrina and Rita underscored how weak the emphasis is in

the public sector on human services. By this, I am not referring to the level of commitment from public health rather I am referring to the allocation of resources. This is an issue of funding. Everyone agrees it is important, yet the funding does not follow.

As a response to this, we at the City have developed a Bureau of Human Services to address the disparity. This service branch houses the varying human services we offered all under one roof now and is now on equal footing with other services such as epidemiology, vital statistics, clinical services, and communicable diseases. And now this bureau actively competes for its equitable share of funding.

In an emergency, we in the public sector must ensure that these services are provided as part of the response and must accomplish this with limited resources and skyrocketing utilization. Traditionally, social services such as job placement, psychological care and substance abuse treatment are provided by niche organizations such as faith-based or community-based organizations. While these groups are varied, they are extremely financially constrained and thus so are there services as well. How do we accomplish this?

To ameliorate this, we must first, act as a coordinating body, brokering relationships between private, public, faith-based and community based organizations, private practitioners and universities to name a few as a means to bolster the services in the short-term.

Second, we must be a political advocate to address the shoestring budgets and the limited staff. We forget that we are governmental entities and must emphasize human services by raising our voices.

This need for expanding human services will only grow exponentially. The emerging concern in preparedness is care and sheltering of special needs. Of additional concern is the fact that there is no one definition. These responsibilities are not going away.

Integrate Emergency Response into the Day-to-Day

All too often preparedness responses are characterized as departures from our day-to-day operations. This is impractical. The scales of economies may change, but the underlying process should remain the same. We must train on the "systems" and "processes" that we will use in an emergency. Additionally, we must mange the expectations of our employees and instill the first responder mentality. Rather than discuss philosophy, let me just provide you examples. 1) Radio use. We train our staffs to use radios in the day to day settings such as clinics so that they its use will be familiar, nay second nature to them. 2) In our mandate to asses the health of our city, we have designed rapid assessment teams that perform community assessment and education. While the model was based on the need to have teams be able to asses "super neighborhoods" in the event of an emergency, we have no integrated our daily operations to build around these functions. Now, such varied groups AAA, TB and communicable disease use the groups as part of their routine outreach. 3) The need to be mobile and integrated into the community to provide on-site services in the event of a natural disaster has allowed us to develop business models to use MSC and libraries as service points for vital statistics. We are even working on providing these services in the school during registration. Once again, we are trying to build a business model that will be the same in wartime as peacetime. 4) Our nursing staff, epidemiology staff, and preparedness staff all have integrated CRI mass vaccination and prophylaxis processes into the routine disease investigation,

outbreak clinics and clinical models. 4) We have built the expectation of 24/7 response in our employees. All employees undergo preparedness training at new employee orientation. The concepts covered include NIMS, Essential Personnel Policy and Personal Disaster Preparedness. Finally, instead of discussing concepts such as telecommuting in the event of a pandemic as strategies, we have altered our work schedules to allow staff to do that now. So, the same strategies we will call upon in an emergency are in use now and building historical data so that we will know if they will indeed work.

Prioritize the Workforce

This is the most critical issue facing public health. There are two issues to be addressed: 1) sufficiency of staff and 2) how we treat existing staff. One must never lose sight of the fact that a strong response calls for the development of infrastructure.

We must be the backbone of the response, but we do not have enough staff. There must be a commitment to recruitment, training and retention of young capable employees. Part and parcel of that is our image. Public health cannot continue to be regarded as health for the have nots. It needs to be on the same level as it is in other countries—preventive medicine. We must actively recruit young minds to become part of our workforce. How many of you actively recruit either directly or through relationships with academic institutions. We have integrated preparedness deliverables with school outreach with training and recruitment. Our staff has faculty appointments with nursing schools, schools of public health, medical schools and other academic institutions and is part of the development of these students by teaching actual classes. We take advantage of every opportunity to introduce these students to public health. It is mutually beneficial. It allows us to answer

deliverables such as training and surge while grooming students to work for us. If there are projects or internship needs, we try to give them the first opportunity to apply. I personally want to lead by example. I came from private practice to be part of public health. I am extremely rewarded by it and want to recruit others like me.

As foe the second issue. The public sector cannot continue to move heaven and earth in a response for others at the expense of our staff and volunteers. We cannot continue to ignore the importance of adequate debriefing and psychological support for our staff. All too often this is forgone simply because resources are not available or we simply cannot afford the down time. We must afford it. This is the pathologic cycle of abuse that is endemic in our field.

An example that readily comes to mind is what happened to me during the Rita evacuation. I was designated an essential employee and so was expected to be there during the hurricane. However, I live in Galveston County which was mandatorily evacuated on Wednesday. I was essentially rendered homeless. I was not alone; there were many others like me. When asked where I was going to say, there was no answer. We have remedied the situation, but not before realizing that his issue was overlooked and caused problems and affected moral. We have since remedied this situation and have one of the most robust essential personnel policies and plans, but not without this difficult lesson.

It is important that my comments are not taking out of context. I am not indicting us, the responders. I am simply acknowledging that the system needs improvements and that policy makers need to understand the effects of their decisions on our already depleted and overworked staff.

Other issues: Training must be more integrated. Not only do we need to train together, but we must train *as* one another. Public health needs to go through fire and law enforcement training even if just superficially. And law enforcement and fire need to be trained in the medicine. This will build trust and camaraderie. Along these lines, there needs to be national standards for incident management and competency-based training that is practical and has public health on the same level as fire, police and EMS.

The holistic solution is that our workforce needs to be an amalgam of public health, volunteers and private sector. This needs to be a purposeful blend, one born out of planning not out of a series of voids and opportunistic marriages.

In summary, these six principles represent our lessons learned. I don't believe they are revolutionary or novel. But our success in the Katrina and Rita response came from implementing these strategies at every level.